

INFORMED CONSENT FOR MEDICATION

Completion of this form is voluntary. If not completed, the medication cannot be administered without a court order unless in an emergency.
This consent is maintained in the client's record and is accessible to authorized users.

Name – Patient / Client (Last, First MI)		ID Number	Living Unit	Birthdate
Name – Individual Preparing This Form		Name – Staff Contact		Name / Telephone Number – Institution

MEDICATION CATEGORY	MEDICATION	RECOMMENDED DAILY TOTAL DOSAGE RANGE	ANTICIPATED DOSAGE RANGE
Antipsychotic Agent (phenothiazine)	Serentil (mesoridazine)	25 mg. - 400 mg.	

The anticipated dosage range is to be individualized, may be above or below the recommended range but no medication will be administered without your informed and written consent.

Recommended daily total dosage range of manufacturer, as stated in *Physician's Desk Reference* (PDR) or another standard reference.

This medication will be administered ☐ Orally ☐ Injection ☐ Other – Specify:

1. Reason for Use of Psychotropic Medication and Benefits Expected (note if this is 'Off Label' Use)

Include DSM IV diagnosis or the diagnostic "working hypothesis".

2. Alternative mode(s) of treatment other than or in addition to medications include (Check all that apply)

Note: Some of these would be applicable only in an inpatient environment.

- | | |
|---|---|
| <input type="checkbox"/> Environment and / or staff changes | <input type="checkbox"/> Rehabilitation treatments / therapy (OT, PT, AT) |
| <input type="checkbox"/> Positive redirection and staff interaction | <input type="checkbox"/> Treatment programs and approaches (habilitation) |
| <input type="checkbox"/> Individual and / or group therapy | <input type="checkbox"/> Use of behavior intervention techniques |

Other Alternatives:

3. Probable consequences of NOT receiving the proposed medication are (Check all that apply)

Impairment of ☐ Work Activities ☐ Family Relationships ☐ Social Functioning

Possible increase in symptoms leading to potential

- | | |
|--|--|
| <input type="checkbox"/> Use of seclusion or restraints | <input type="checkbox"/> Limits on recreation and leisure activities |
| <input type="checkbox"/> Limits on access to possessions | <input type="checkbox"/> Intervention of Law Enforcement |
| <input type="checkbox"/> Limits on personal freedoms | <input type="checkbox"/> Risk of harm to self or others |
| <input type="checkbox"/> Limit participation in treatment activities | |

Other consequences

Note: These consequences may vary, depending upon whether or not the individual is in an inpatient setting. It is also possible that in unusual situations, little or no adverse consequences may occur if the medications are not administered.

4. Possible side effects, warnings and cautions associated with this medication are listed below. This is not an all inclusive list but is representative of items of potential clinical significance to you. For more information on this medication, you may consult further with your physician or refer to a standard text such as the PDR or the United States Pharmacopoeia Dispensing Information (USPDI). As part of monitoring some of these potential side effects, your physician may order laboratory or other tests. The treatment team will closely monitor individuals who are unable to readily communicate side effects, in order to enhance care and treatment.

Continued – Possible side effects, warnings and cautions associated with this medication.

The most common side effects include muscle spasms of the neck and back, shuffling walk, tic-like (jerky) movements of the head, face and neck; trembling and shaking of the hands and fingers; inability to move eyes; loss of balance control; blurred vision, change in color vision or difficulty in seeing at night; difficulty speaking or swallowing; constipation, drowsiness, dizziness, dry mouth, nasal congestion, decreased sweating and increased sensitivity of the skin to the sun and Tardive Dyskinesia (lip smacking or puckering, puffing of cheeks, rapid or fine worm-like movement of tongue, uncontrolled chewing movement, uncontrolled movements of arms and legs may occur and may not go away after stopping use of the medication).

Less common side effects include difficult urination; changes in menstrual period; decreased sexual ability; increased sensitivity of skin to sunlight (skin rash, itching, redness or other discoloration of skin or severe sunburn); swelling or pain in breasts; unusual secretion of milk; unusual weight gain

Rare side effects include convulsion, seizures; difficult or fast breathing; fast heartbeat or irregular pulse; fever; high or low blood pressure; increased sweating; loss of bladder control; severe muscle stiffness; unusually pale skin, unusual tiredness or weakness; abdominal or stomach pains; aching muscles and joints; confusion; fever and chills; hot, dry skin, or lack of sweating; muscle weakness; nausea, vomiting or diarrhea; painful continuing inappropriate penile erection; skin discoloration (tan or blue-gray); severe skin itching; sore throat and fever; unusual bleeding or bruising, yellow eyes or skin; Malignant Neuroleptic Syndrome (an unusual reaction that results in poor control of temperature, vital signs and muscle tone). Potentially fatal blood cell abnormalities which may be prevented by careful monitoring and regular lab tests.

See PDR, USPDI or American Hospital Formulary Service for all-inclusive list of side effects.

By my signature below, I GIVE consent for the named medication on Page 1 and anticipated dosage range. My signature also indicates that I understand the following:

1. I can refuse to give consent or can withdraw my consent at any time with written notification to the institution director or designee. This will not affect my right to change my decision at a later date. If I withdraw consent after a medication is started, I realize that the medication may not be discontinued immediately. Rather it will be tapered as rapidly as medically safe and then discontinued so as to prevent an adverse medical consequence, such as seizures, due to rapid medication withdrawal.
2. Questions regarding this medication can be discussed with the Interdisciplinary Team, including the physician. The staff contact person can assist in making any necessary arrangements.
3. Questions regarding any behavior support plan or behavior intervention plan, which correspond with the use of the medication, can be directed to the client's social worker, case manager or psychologist.
4. I have the right to request a review at any time of my record, pursuant to ss. 51.30(4)(d) or 51.30(5)(b).
5. I have a legal right to file a complaint if I feel that client rights have been inappropriately restricted. The client's social worker, case manager or agency / facility client rights specialist may be contacted for assistance.
6. My consent permits the dose to be changed within the **anticipated dosage range** without signing another consent.
7. I understand the reasons for the use of the medication, its potential risks and benefits, other alternative treatment(s) and the probable consequences, which may occur if the proposed medication is not given.
8. This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature. The need for and continued use of this medication will be reviewed at least quarterly by the Interdisciplinary Team. The goal, on behalf of the client, will be to arrive at and maintain the client at the minimum effective dose.

SIGNATURES

DATE SIGNED

Client – If Presumed Competent to Consent / Parent of Minor / Guardian	Relationship to Client <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	
Staff Present at Oral Discussion	Title	

Client / Parent of Minor / Guardian Comments